

Tips for Working with Anxious Patients

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Remember your personal power as a therapeutic agent.

Assess the context of the anxiety--what is going on? Listen to the patient's story.

Begin to diagnose the type of anxiety disorder. All diagnoses are hypotheses which can change as you gather information over time.

Help the patient accept their anxiety--at least some part of it they can live with.

Re-frame anxiety as a useful tool, although sometimes it goes awry.

Don't feel pressured by the patient's pressure.

Reassure the patient that s/he is not going crazy.

Teach abdominal breathing, progressive relaxation, positive imagery, or some other relaxation technique, or recommend a relaxation tape.

Encourage aerobic exercise.

Help the patient identify triggers for anxiety.

Help the patient identify positive coping strategies (learning to think differently).

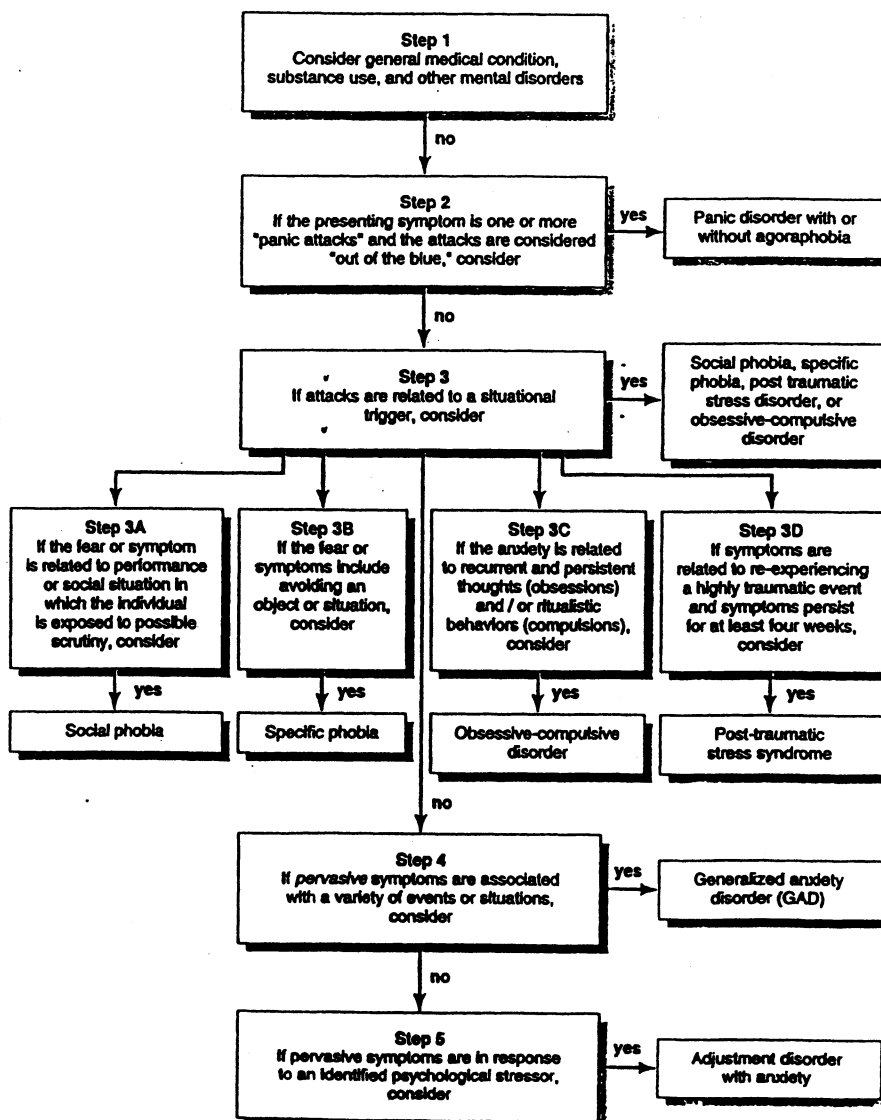
Work with the patient over time.

Refer patients for psychotherapy when indicated.

DIAGNOSING ANXIETY

Disorder	Questions
Generalized anxiety disorder	Would you describe yourself generally as a nervous person? Are you a worrier? Do you feel nervous or tense?
Panic disorder	Have you ever had a sudden attack of rapid heartbeat or rush of intense fear, anxiety, or nervousness? Did anything seem to trigger it?
Agoraphobia	Have you ever avoided important activities because you were afraid you would have a sudden attack like the one I just asked you about?
Social phobia	Some people have strong fears of being watched or evaluated by others. For example, some people don't want to eat, speak, or write in front of people for fear of embarrassing themselves. Is anything like this a problem for you?
Specific phobia	Some people have strong fears or phobias about things like heights, flying, bugs, or snakes? Do you have any strong fears or phobias?
Obsession	Some people are bothered by intrusive, silly, unpleasant, or horrible thoughts that keep repeating over and over. For example, some people have repeated thoughts of hurting some one they love even though they don't want to; that a loved one has been seriously hurt; that they will yell obscenities in public; or that they are contaminated by germs. Has anything like this troubled you?
Compulsion	Some people are bothered by doing something over and over that they can't resist, even when they try. They might wash their hands every few minutes, or repeatedly check to see that the stove is off or the door is locked, or count things excessively. Has anything like this been a problem for you?
Acute stress and posttraumatic stress disorder	Have you ever seen or experienced a traumatic event when you thought your life was in danger? Have you ever seen someone else in grave danger? What happened?

ALSO CONSIDER DEPRESSION WITH ANXIETY



APPENDIX E: INFORMATION TO CONVEY TO CLIENTS WHO EXPERIENCE PANIC ATTACKS

1. Panic attacks are a *sudden onset* of intense apprehension, fear or terror, often associated with feelings of imminent danger and impending doom.
2. Panic attacks are made up of *several components* including physiological reactions (sensations), feelings (apprehension, fear, anxiety), thoughts (predictions, expectations), and behaviors (hyperventilation, avoidance behaviors).
3. The individual's thoughts (e.g., predictions) may act as a self-fulfilling *prophecy* by leading to avoidance behaviors that preclude and limit opportunities to confront and master fears that are experienced in discomforting situations.
4. These components *interact* in ways that can *escalate* and *contribute* to a "vicious cycle." How debilitating a panic attack may be *will vary across situations* and *over time*. The monitoring of such variable patterns can often "inform" the client and therapist, providing "hints" as to ways the client can control, reduce, anticipate, and even prepare for possible panic attacks. The vicious cycle can be broken and reversed.
5. Such panic reactions occur in the *normal population* (approximately 10-20%) and this reflects the body's natural reactions to the perception of personal threat and imminent danger. The symptoms of palpitations, sweating, and breathlessness are all natural automatic ways for individuals to prepare their bodies for a "fight or flight" situation. Such bodily symptoms are normal evolutionary processes and *not* catastrophic events that should be suppressed. In fact, efforts to actively suppress such normal reactions can backfire and have just the opposite effect of exacerbating the panic attacks.
6. As noted, the "*wisdom of the body*" is operating when an individual perceives imminent threat or danger and responds in an automatic "fight or flight" fashion. Such anxiety serves a vigilance function anticipating and preparing to cope with perceived threats. Then, what *distinguishes* individuals who experience panic attacks on a frequent basis from the nonclinical population who may occasionally have a panic attack? One major difference is that the panic patient is hypervigilant and hypersensitive to such situational and bodily signs. Second, clients often respond when there is no objective danger in the form of what researchers call a series of "false alarms." The predisposition or tendency of patients with panic attacks to engage in such "fast action automatic responses" can be changed and controlled. It is as if the patient with panic attacks is on "*sentry duty*" all the time. At one time such vigilance may have been adaptive, but now it occurs at a high price and can take an emotional and behavioral toll. These reactions do not mean that someone is going crazy, but rather is just "*stuck*" using a coping technique that may have been useful in the past, but is *not self-serving* at this time.
7. Such bodily reactions are often *misperceived* as being a sign of "having a heart attack," "losing control," "going crazy," even "going to die." Such

appraisals will make the anxiety worse and feed into further panic, and so the cycle can "*spiral*."

8. Such fears are often accompanied by hyperventilation. Hyperventilation is the elimination of carbon dioxide which occurs at a faster rate than its production in the tissues. Hyperventilation has a direct effect on the individual's bloodstream, changing the balance or the ratio of carbon dioxide to oxygen in the bloodstream. Portions of the lower brain stem are particularly sensitive to these chemical changes. The immediate consequence of hyperventilation is a drop in carbon dioxide. If the hyperventilation is intense and lasts long enough (more than three minutes), it can cause secondary physiological changes such as tingling sensations, cold hands or feet, dizziness, faintness, stiff muscles, and trembling. Such bodily changes may be perceived as similar to panic attacks. It is important that the therapist demonstrate for the client (and significant others) the difference between hyperventilation and self-regulated breathing and how such controlled breathing can significantly reduce arousal. Such breathing control is a *skill* that can be learned with practice at home.
9. Such panic attacks may be discomforting and distressing, but they are *not life-threatening*. In fact, such panic attacks will lessen with time and decrease as the individual's perception of danger is reduced, especially if the individual can begin to *control* the accompanying ideation of "*catastrophic misperception*."
10. Panic attacks that individuals experience may take different forms. For some, panic attacks are experienced as occurring *all of a sudden* ("out of the blue") whereas for others, the panic attacks may be *tied to specific situations*. Some may even experience panic attacks during sleep, while others have such attacks only during the day. For some, the fear of "suffocating" may represent a major clinical feature, occurring earliest in the chain of the onset of the panic attack and standing out most. For others, such feelings of suffocation may not play a central role.
11. There are *effective treatments* that can help clients (1) *recognize* when such physical sensations occur; (2) *notice* their accompanying tendency to misinterpret these bodily signs; (3) *catch* themselves when beginning to hyperventilate; (4) *interrupt* the vicious cycle; (5) call upon a *game plan* to cope more effectively; (5) exert "*personal control*" in order to "*take charge*" and *reverse* the vicious cycle; and (6) *take credit* for and *pride* in the changes they are able to bring about.
12. In addition, there is a need to recognize that a number of *accompanying problematic behaviors*, such as self-medication, drinking, and avoidance behaviors that may have "worked" in the short-run to reduce anxiety and avoid fear-engendering situations, may cause additional problems. In the long-run alternative, more adaptive "coping efforts" need to be developed and practiced.
13. Often the onset of panic attacks is *preceded* by other *life stressors* that should be discussed and addressed in therapy.

14. Such panic attacks are often (not in all cases) accompanied by feelings of helplessness, hopelessness, sadness, and *depression*. These feelings may precede, accompany, or result from the experience of panic attacks. The depression may also arise from feelings of *current loss*. The depression may be tied to *interpersonal difficulties* and *conflict* that clients are experiencing with significant others (family members, coworkers, friends), or tied into *frustration and disappointment* with not achieving some valued goals. There is value in exploring these issues, especially once the panic attacks are brought under better control.
15. Finally, in a *percentage* of cases the experience of panic attacks and accompanying depression may be tied into an "*unresolved loss*" experienced in the past (e.g., the death of a family member, divorce, or a neglectful parental relationship) that may take the form of "unfinished grieving." In some (*not all*) instances the current clinical picture may be tied to some *experienced corroborated* instance of *victimization* that may take the form of physical or sexual abuse, harsh discipline, or continual severe criticism that affects an individual's sense of self-esteem and self-worth. *Such victimization experiences are not present in the background of all clients with panic attacks and depression*, but if present, the client and the therapist should explore together the value of examining this material in therapy. Such discussion and exploration may follow or occur in tandem with the immediate need for the client to learn to control and reduce his or her panic attacks.
16. Any discussion of panic attacks and depression should be *balanced* with a *discussion* of the client's *strengths, resilience and courage*. There is a need for the client to tell his or her "*whole story*." The panic attacks and depression are only part of the story. The client and therapist need to be sure to cover "the rest of the story."

Primary Care Psychiatry and Behavioral Medicine

*Brief Office Treatment
and Management Pathways*

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care physician, it is vital that clinicians in primary care practices be informed and equipped to recognize and deal with psychiatric disorders, including anxiety and panic.

This chapter will review a biopsychosocial approach to anxiety disorders and will provide the following: an anxiety disorder algorithm and guidelines for differential diagnosis, a clinical review of anxiety disorders, screening instruments for anxiety disorders, a discussion of the physiological and psychological basis of anxiety disorders, recommendations for office-based treatment, a critical pathway for treating panic disorders, and patient education and resources.

ANXIETY DISORDER ALGORITHM AND DIFFERENTIAL DIAGNOSIS

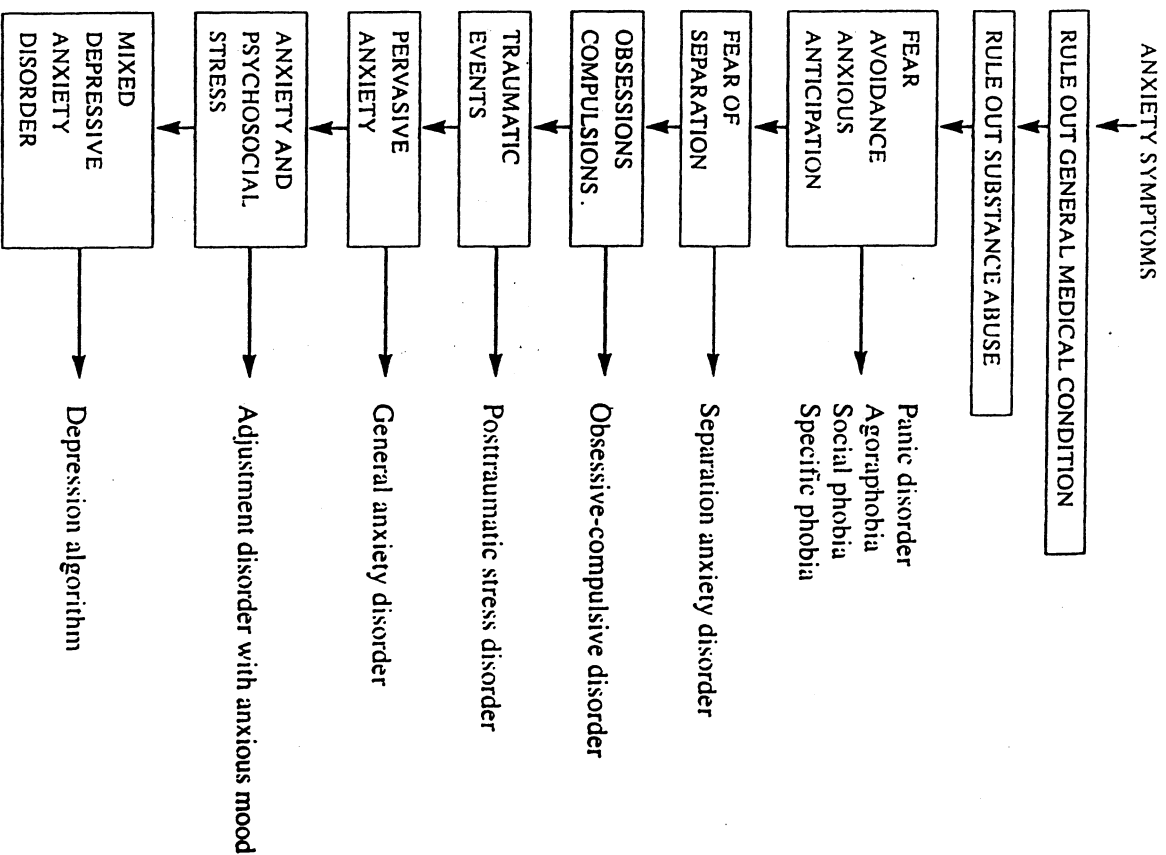
Diagnosis

The first step in the work-up and treatment of anxiety disorders is to evaluate the patient for general medical conditions and substance-induced anxiety disorders. The anxiety disorder algorithm in the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Diseases Primary Care Version* (1995, DSM-IV-PC) describes the general approach toward the work-up and differential diagnosis of anxiety disorders. Figure 2.1 summarizes the algorithm.

General Medical Conditions Producing Anxiety Symptoms

There are many medical causes for anxiety symptoms. The most common are hyperthyroidism, hypoglycemia or diabetes, cardiovascular disorders (arrhythmias, myocardial infarction, congestive heart failure, cardiomyopathy, cardiac transplantation, mitral valve prolapse), audiovestibular disorder, partial-complex seizures, Parkinson's disease, and pheochromocytoma.

The work-up for anxiety disorders should include a detailed medical and psychiatric history, physical examination, mental status examination, and relevant laboratory testing. The latter may include (1) common laboratory studies such as glucose, calcium, phosphate, and thyroid studies (more rarely used are arterial blood gases, catecholamines and cortisol levels, autoimmune screening, and ceruloplasmin if clinically indicated); (2) urine drug screens as appropriate; and (3) common diagnostic testing,



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Figure 2.1 Anxiety Algorithm.

Table 2.2 Drugs Known to Produce Anxiety Symptoms

Drug Intoxications	Drug Withdrawal	Medications	Psychiatric Medications	Exposure to Environmental Toxins
<ul style="list-style-type: none"> • Caffeine • Alcohol • Cocaine • Amphetamines • Cannabis • Hallucinogens • Inhalants • Phencyclidine 	<ul style="list-style-type: none"> • Alcohol • Sedatives/hypnotics • Opiates • Cocaine 	<ul style="list-style-type: none"> • Antihypertensive and cardiovascular medications • Calcium channel blockers and digitalis • Sympathomimetics and bronchodilators • Anesthetics • Analgesics • Anticholinergic and anti-Parkinson's agents • Insulin • Thyroid preparations • Oral contraceptive and/or hormone replacements • Antihistamines • Anticonvulsants 	<ul style="list-style-type: none"> • Lithium • Antidepressants • Antipsychotics 	<ul style="list-style-type: none"> • Gasoline • Paint • Organophosphate insecticides • Carbon monoxide • Carbon dioxide • Nerve gas

abruptly without a stimulus and is experienced as an intense feeling, or panic that develops quickly and peaks within 10 minutes. Symptoms of a panic attack can be cardiac, autonomic, gastrointestinal, neurological, or psychiatric in nature. The most common symptoms are noncardiac chest pain, shortness of breath, fear of impending doom, fear of going crazy, and feeling dizzy or faint. Less common symptoms of panic, which may go unrecognized, include fear of choking, nausea or vomiting, sweating or hot flashes, feelings of unreality or detachment from oneself, trembling, and paresthesias.

When patients present to a primary care physician, physical complaints often get all the attention. It is important to remember that panic can present with cognitive symptoms: the fear that something catastrophic will happen; affective symptoms including terror, heightened arousal, anticipatory anxiety, and feelings of depression; and behavioral symptoms, such as withdrawal, dependency, and avoidance of the phobic situation.

Some patients who have panic attacks may also develop agoraphobia. Agoraphobia is anxiety about being unable to exit or escape. Common agoraphobic symptoms include a fear of riding buses or planes; a fear of open spaces, such as supermarkets; a fear of elevators, subways, or bridges; or a more global and severe fear of leaving home. *DSM-IV-PC* describes three possible forms of panic disorder: panic attacks with agoraphobia, panic attacks without agoraphobia, and panic attacks within the context of other anxiety disorders.

One system for understanding the relationship and overlap of panic disorder, phobia, agoraphobia, and depression has been described as the seven stages of the natural history of endogenous anxiety (Sheehan, 1983). Many patients progress through an anxiety sequence by experiencing subpanic attacks (stage 1), which typically progress to full panic attacks (stage 2). With many panic and/or subpanic attacks patients develop a somatic preoccupation that becomes hypochondriasis (stage 3). Patients often progress and become avoidant of the location of the attack and develop a single phobia (stage 4), such as fear of riding a bus. If panic attacks continue, there is further avoidance of multiple sites of panic, and the patient progresses to more general avoidance of social situations, or social phobia (stage 5). As new phobic situations develop, the patient becomes phobic and agoraphobic and at the extreme may be homebound (stage 6). When undiagnosed or untreated, these panic and polyphobic states easily progress to depression (stage 7).

Course of Social Phobia

Patients who develop social phobias may have a childhood history of social inhibition or shyness. The social phobia typically develops in the mid-teens, either emerging insidiously or, conversely, emerging acutely after an incident, such as a publicly humiliating experience. This disorder is typically lifelong and may fluctuate with stress, specific phobic situations, and demands placed on the individual. It is sometimes clinically difficult to distinguish a social phobia from a feeling of embarrassment over a ritual or a public panic attack.

Specific Phobia Signs and Symptoms

A specific phobia is a persistent fear, anxiety, or panic attack that is precipitated or cued by a specific object or nonsocial situation. Individuals suffering with a specific phobia recognize that their fear is excessive or unreasonable and avoid those things or situations that provoke the anxiety. Typical specific phobias are fear of animals, most commonly dogs; fear of the environment, typically heights, water, or the weather; fear of blood, or injection injury; and fear of certain situations, such as planes, elevators, and tunnels. Traumatic events often precipitate a simple phobia. For example, a dog bite can precipitate a dog phobia.

Course of Specific Phobia

A specific phobia usually begins in childhood but can also emerge as new symptoms in the 20s. Phobias are exceedingly common in children but with so little impairment that no psychiatric diagnosis is warranted. In adults, phobias are also common and may not result in any impairment. To meet the criteria for a specific phobia, a phobia must cause significant daily distress and/or social and occupational dysfunction.

Epidemiology

Social phobia has a lifetime prevalence of 13.3%. It is the third most common psychiatric disorder in the United States. Specific phobia has a prevalence rate that varies with the threshold used to determine distress and social or occupational dysfunction. In community samples reported in the DSM-IV (1994), lifetime prevalence rates were 10% to 11.3%, and the 1-year prevalence rate was 9%.

Clinical Issues

The primary care clinician often misses or only incidentally discovers a phobia during a medical encounter or during diagnostic testing. Patients who have phobias to blood, injections, injuries, dental phobia, or even claustrophobia are often terrified by medical procedures or settings. Phobic patients may also confront the physician with unanticipated problems, such as severe distress during procedures such as colonoscopy or pelvic or rectal exams, or may develop claustrophobic panic during a CAT scan or MRI test. Patients undergoing these procedures may experience a marked distress and/or a panic attack and may be unable to complete the requested diagnostic testing or procedure.

On the opposite side of the spectrum, when there is no phobic stimulus present, a clinician may have no idea that a phobic disorder exists. Patients may actively avoid discussing phobias. This is not out of a desire to withhold information but rather the primary defense of avoidance, which attempts to make phobic symptoms disappear from view.

Clinicians should suspect phobias when they hear about difficulties at work, at school, in interpersonal relationships, or when the patient describes panic or anxiety in public situations. The clinician should specifically ask about fear of blood, injections, procedures, water, and claustrophobia and encourage the patient to acknowledge any fears of flying, elevators, bridges, tunnels, heights, animals, and storms. It is common for an adult to have a history of a phobia as a child, and a history of a parental death before the age of 17 is associated with increased risk for phobias. Social phobia with panic can be differentiated from panic disorder. Panic episodes with panic disorder are unexpected and not cued by the environment, whereas panic attacks from phobias occur in social situations or are precipitated by the feared objects.

Social phobia and specific phobia may need to be differentiated from avoidant personality disorder. This differentiation can be difficult and often requires referral to a mental health professional.

Obsessive-Compulsive Disorder*Signs and Symptoms*

Obsessions are recurrent thoughts, impulses, or images that cause marked distress or anxiety. Repetitive thoughts are intrusive, unwanted, and may even feel senseless, and they go beyond worry about real-life problems.

that may represent the event. In addition, the patient avoids stimuli associated with the trauma, reports a numbing of general responsiveness, and may also experience an increase in arousal such as insomnia, startle response, or hypervigilance. These symptoms must last for at least 1 month and can cause significant distress and/or impairment in social or occupational functioning.

Traumatic events involve actual threatened death or injury, a threat to bodily integrity such as rape, or natural disasters such as floods. Traumas can be experienced directly or may be observed. Patients often describe survival guilt and avoidance of any situation or people that bring back memories of the traumatic event. Patients suffering with PTSD often develop interpersonal difficulties such as marital conflict, divorce, occupational and social dysfunction, and substance abuse. Many researchers believe that childhood PTSD, from child abuse or neglect, can lead to the development in adults of borderline personality disorders and dissociative identity disorders (formerly multiple personality disorder).

Course of Posttraumatic Stress Disorder

PTSD can occur at any age, even in childhood. Symptoms usually begin within 3 months of the trauma but can begin months and sometimes years later. Complete recovery occurs within 3 months in 50% of patients, but others can have symptoms for years. The severity, duration, proximity, and repetitions of multiple traumas increase the likelihood of developing the disorder. The magnitude of the trauma, the persistence of community devastation, the real-life sequelae from the trauma, and the patient's coping capability affect the ultimate outcome of this disorder (see chapter 17, Crisis Intervention in Office Practice).

Epidemiology

The lifetime prevalence of PTSD is 1% to 14% in community samples and varies with the population and methodology of the studies. People at risk, such as military personnel and natural disaster victims, have higher prevalence rates.

Clinical Issues

One excellent approach to interviewing patients with PTSD is the crisis intervention approach, as detailed in chapter 17.

Generalized Anxiety Disorder (GAD)

Signs and Symptoms

Generalized anxiety disorder (GAD) is an illness of chronic worry. *DSM-IV-PC* diagnostic criteria for GAD specify excessive worry that is pervasive and difficult to control, that lasts for at least 6 months, and that occurs for more days than not. Associated symptoms include trembling, muscle tension, dry mouth, palpitations, and symptoms of hyperarousal such as a startle response or insomnia. These symptoms must cause clinically significant distress and impairment in social and/or occupational functioning.

A diagnosis of GAD should be considered only if the anxiety is not better accounted for by another disorder, because GAD symptoms are often present with panic disorder, obsessive-compulsive disorder, social phobia, hypochondriasis, posttraumatic stress disorder, and depression.

Course of the Illness

Many patients with GAD report lifelong histories of worrying with the onset occurring in childhood or adolescence. GAD may have more of a personality component than other anxiety disorders. The course is typically chronic and is worsened by acute stress.

Epidemiology

DSM-IV indicates that GAD has a lifetime prevalence rate of approximately 5% and a 1-year prevalence rate of 3%. In specialty services for anxiety disorders, approximately 12% to 15% of patients present with GAD.

Clinical Issues

One problem with the classification of anxiety disorders in both the *DSM-IV* and *DSM-IV-PC* is that it focuses on anxiety syndromes as illnesses or diseases. GAD appears to be more of a psychological illness than a disorder with genetic underpinnings. Rather than approaching GAD as an illness or disease, the clinician can work with the patient to try to understand the source of the patient's anxiety. GAD often can be linked to separations or fear of separation. Anxiety symptoms may arise from fear of loss of love, fear of bodily harm, pangs of conscience, or anxiety over not living up to an internal moral code. It is important to recognize that GAD is very responsive to psychotherapy provided by a mental health professional.

Generalized Anxiety Disorder

Sixty-six percent of patients suffering with GAD respond rapidly within 1 to 2 weeks to benzodiazepines. Most physicians will first try short-acting medications PRN such as lorazepam 1 to 4 mg PRN; alprazolam, 0.25 to 1 mg PRN; or oxazepam, 10 to 40 mg PRN. The PRN approach is efficacious in part because in the short term, patients with GAD have a high placebo rate of approximately 50% to 60%. If the short-acting PRN approach doesn't bring relief, then a switch to long-acting, potent benzodiazepines is suggested. Clonazepam at 0.5 to 2 mg/day or chlor-diazepoxide at 25 to 75 mg/day are often used.

If symptoms of GAD are not acute or severe, buspirone can be a very effective alternative. There are no acute effects of buspirone except for the placebo effect. The initial effect of buspirone is in 1 to 2 weeks, and a full effect may take 4 to 6 weeks. This medication works better when the patient is free from benzodiazepines for 1 month. Typical starting doses are 5 mg tid for the first week, with increases of up to 5 mg every 2 to 4 days until a dose of 30 mg/day is reached within 2 weeks. Doses can go as high as 60 to 80 mg/day.

Several studies have also shown that imipramine, 10 to 300 mg, and trazodone in doses of 25 to 600 mg are also effective for GAD, independent of depression or panic.

Many patients with GAD may require long-term maintenance therapy, because 50% of these patients have symptoms for more than 5 years. There have been no long-term studies that address the duration of therapy. Psychotherapy may provide a better long-term treatment result if the patient is willing and able to undertake it.

DESENSITIZATION: EXPOSURE TO PHOBIC SITUATIONS OR OBJECTS

Once panic and acute anxiety symptoms are under control with medications, breathing control, or relaxation response training, it is important to help the patient to cease avoiding phobic situations and objects. Medications control panic but do not treat the avoidance behaviors themselves. The patient must be reintroduced to fearful situations or objects once the panic attacks or severe anxiety are markedly reduced, to over-

come phobic or avoidant behavior. The two major methods of exposure are called graduated desensitization and flooding.

Graduated desensitization is exposing the patient to the phobic object or fearful situation, initially through imagery and eventually through real contact with the phobic situation. This graduated exposure to the fear is under the patient's control. Have a patient (who may or may not be on medication) imagine the fearful situation (e.g., public speaking) while practicing relaxation techniques. It is important that the patient practice, often several times a day, imagining the situation or phobic object while practicing relaxation. Repeated imagined gradual exposures will diminish the patient's fear.

After imagined exposure, the patient needs to use the relaxation techniques during a graduated exposure to the real-life situation. Some patients need a friend, family members, or a mental health professional to assist them in confronting the situation.

Flooding is an intensive total immersion in a phobic situation or continuous contact with the phobic object. For example, treatment of an eating-in-public phobia or germ phobia requires eating in public or continuous exposure to dirt for several days or weeks. Flooding is an exceedingly quick and rapidly effective treatment for phobias and obsessive-compulsive rituals. Patients learn relaxation techniques first, may be given medication, then are flooded with the phobic stimuli. This is an intensive experience that can be emotional and frightening. It is usually accomplished with the aid of a mental health professional over a period of several days to weeks.

COGNITIVE-BEHAVIORAL THERAPY

Cognitive behavioral therapy is a very effective treatment for all the anxiety disorders. Cognitive theory suggests that anxiety symptoms are caused by a patient's basic belief system, a stimuli, a cognitive or mental misappraisal of the stimuli, and a hot thought, all of which lead to emotions such as anxiety, fear, phobia, and obsessions/compulsions. An example of a cognitive behavioral diary for anxiety is illustrated in Figure 2.2 and discussed in detail in chapter 19, Behavioral Counseling and Medical Adherence. Hot thoughts that are associated with various anxiety disorders are summarized in Table 2.6.

Families Suffer

Living with someone who suffers with panic attacks, agoraphobia, OCD, PTSD, and other anxiety disorders can have profound interpersonal consequences for the patient's marital partner and children. Patients with anxiety symptoms may not be able to drive, appear in public, develop friends, or work and may avoid intimacy or be unable to experience life's pleasures. Children of anxious parents may develop a marked fear of the world, which can pave the way for the next generation of anxiety disorder and interpersonal, social, and occupational dysfunction.

Families Can Help

Families can be a tremendous aid in treating patients with anxiety disorders. Family members can offer additional information that can facilitate diagnosis, describe the major problematic areas, provide a buffer for the patient during times of fear and stress, act as health advocates, help the patient access community resources, and be invaluable therapy assistants, especially as cotherapists for behavioral/exposure treatment.

Families Can Hinder Treatment

Sometimes, families inadvertently or consciously support an illness or a phobia in a family member, because aspects of an individual's illness may help the family. When treatment of an anxiety disorder is not successful or is only partially helpful, it is necessary to examine the positive aspects of the illness for the family. Once these issues are addressed with the family, the patient may then be able to recover. For example, a phobic housebound woman was encouraged by her husband and working-age sons to stay home, cook, clean, and care for her family. Her efforts to overcome her agoraphobia were actively discouraged, because her leaving home meant additional work for the other family members.

CRITICAL PATHWAYS: PANIC DISORDER

A panic disorder critical pathway is illustrated in Table 2.7, which provides primary care guidelines for screening evaluation, psychopharmacology, and psychosocial treatment of panic over a 1-year time period.

Table 2.7 Critical Pathway: Panic Disorder

	Initial Visit	Week 2	Week 3	Week 4	Weeks 8-10	Months 6-9	Months 9-12
Assessment tools	Beck & Steer, ^a Burns, ^a or Hamilton stress scale; ^d GAF ^c or GARP scales	Anxiety algorithm; ^e GAF; ^d anxiety scale; ^e or cognitive behavior diary ^a		GAF; ^c anxiety scale ^e or cognitive behavior diary ^a	Beck & Steer, ^a Burns, ^a or Hamilton stress scale ^d	GAF; ^c anxiety scale; ^e or cognitive behavior diary ^a	Beck & Steer, ^a Burns, ^a or Hamilton stress scale; ^d GAF; ^c GARP anxiety scale; ^e or cognitive behavior diary ^a
Physical/lab/diagnostic tests	1. Full PE 2. Chemistry panel 20, Drug screen, Electrocardiogram (EKG), Venereal Disease Research Laboratory Test (VDRL), Thyroid Function Test (TFT), Thyroid Stimulating Hormone (TSH).	Check lab results and treatment. Consider ECHO.		Check labs. Drug screen? ^f Labs: VMAs, EEG? ^g CAT/MRI? ^h	If (-) responses, reevaluate diagnosis.		

continued

Table 2.7 (continued)

	Initial Visit	Week 2	Week 3	Week 4	Weeks 8-10	Months 6-9	Months 9-12
Treatment (continued)	b. If severe panic, alprazolam tid or clonazepam bid. c. If mild or occasional panic, lorazepam PRN or oxazepam PRN. d. TCAs. e. MAOIs.			range? Adjust PRN b. Change or add a new antidepressant? c. Taper/ d/c benzo PRN if possible. d. If necessary, use clonazepam or alprazolam maintenance.	if possible b. Combination benzo and antidepressant maintenance required? c. Dose adjustments PRN.	months, consider taper b. No benzo if possible c. Maintain antidepressants or combination as necessary New medications, if appropriate.	b. Discontinue all drugs. c. Drug maintenance as necessary. New medications, if appropriate.
Consultations	If suicidal, consider psychiatric consultation.	Medical specialist, if required.	Consider family visit and/or psychiatric consultation.	Consider psychiatric consult and/or referral to psychotherapy.	If (-) response. DEFINITE TREATMENT REFERRAL	Referral? Psychotherapy? Psychopharmacology?	Referral? Psychotherapy? Psychopharmacology?
Physician or clinician counseling/ intervention	1. Breath control (BC). 2. Relaxation response training (RRT). 3. Stressors 4. Social support	GAF ^a review: 1. BC 2. RRT 3. Stressors 4. Social support	As necessary.	GAF ^a review/ Mood rating Cognitive behavior diary ^a Meds	GAF ^a review Review cognitive mood rating Cognitive diary ^a	GAF ^a review Review cognitive behavior diary/ medications.	GAF ^a review Review cognitive behavior diary/ medications.

	Initial Visit	Week 2	Week 3	Week 4	Weeks 8-10	Months 6-9	Months 9-12
Counseling/ intervention (continued)	3. Social support. 4. Stresses. 5. Decrease caffeine, smoking.	5. Mood rating. 6. Cognitive behavior diary. ^a Extra phone availability.	Extra phone availability.	Review: 1. BC. 2. RRT. 3. Stresses. 4. Separation issues. 5. Exercise.	Social support. Medications. Antiphobia Rx. Review Rx. (-) Response: reassess, diagnosis and treatment.	Continue to treat phobic symptoms.	Continue to treat phobic symptoms.

Developed by: Robert E. Feinstein

^aBeck, A. T., & Steer, R. A. (1990). *Beck anxiety inventory*. San Antonio, TX: Psychological Corp. Harcourt Brace.

^bBurns, D. (1989). *The feeling good handbook*. New York: Penguin Books.

^cHamilton, M. A. (1959). The assessment of anxiety states by rating. *British Journal of Psychiatry*, 32, 50.

^dHolmes, T. H. & Rahe, R. H. (1967). Stress scale: Social readjustment scale. *Journal of Psychosomatic Research*, 2, 213.

^eGAF (Global Assessment of Functioning) scale. American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed., p. 200). Washington, DC: Author.

^fGARF (Global Assessment of Relational Function) family assessment scale. *DSM-IV*, pp. 758-759.

^gAnxiety algorithm; see Figure 2.1.

^hCognitive behavior diary; see Figure 2.2.

Panic Disorder

CLINICAL PRACTICE GUIDELINE *for the* TREATMENT *of*

in PSYCHIATRY, 2ND EDITION-SUMMARY

ENDORSED BY:

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Panic Disorder

in PSYCHIATRY, 2ND EDITION—SUMMARY

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INTRODUCTION

- This guideline is a summary version of the longer, comprehensive Clinical Practice Guideline for the Treatment of Panic Disorder in Psychiatry, 2nd Ed. The long version is available via Lotus Notes in the Kaiser Permanente Clinical Library (cl.kp.org) and on hard copy. Those interested in learning more about the disorder and the research behind the treatment recommendations therein are strongly encouraged to access and read it. *The longer version has all the references substantiating the findings.*

The summary version you are holding was prepared in a "user-friendly" format for every clinician.

The "road maps" for clinicians, administrators, and patients are designed to help us deliver a uniform message and up-to-date treatment package.

PDSS

The Panic Disorder Severity Scale (Shear, Brown, Barlow, et al., 1997) is used to assess panic frequency, anxiety about panics, agoraphobic avoidance, and interference with functioning. This is a reliable and valid instrument, where a cut-off score of 8 may indicate diagnosis-level symptoms (Shear, Rucci, Williams, et al., in press). A score of less than 8 is currently viewed as a reasonable target for remission in clinical outcome work. We have received permission to use the PDSS-Self Report version within Northern California Kaiser.

CLINICAL CARE

This quick reference summarizes the recommended steps in the assessment and treatment of panic disorder.

This information is intended for key administrators in each clinic. It outlines the necessary resources and programs required to implement the services needed for those who suffer from panic disorder.

This tip sheet, edited and distributed by Health Education, describes briefly the nature of panic disorder and treatment options. It is important that clinicians do *not* give patients information *inconsistent* with that on the tip sheet.

Panic disorder has a lifetime prevalence of 3.5%. The onset can occur anywhere over the life span, though it most typically begins between late adolescence and the late 20's or early 30's. Panic disorder is a learned fear of the uncomfortable physical sensations associated with panic. These events are experienced as uncontrollable and interpreted as catastrophic. The DSM-IV (American Psychiatric Association, 1994)

describes panic disorder as recurrent, unexpected panic attacks accompanied by chronic apprehension about having another panic attack, or by concern about the consequences of having a panic attack, or by some significant behavior change associated with the attacks. The diagnosis requires at least two spontaneous attacks not cued by specific situational triggers. Patients describe such attacks as occurring "out of the blue." The DSM-IV definition of panic disorder implies a psychobiological conceptualization. It allows for the possibility of experiencing multiple physical symptoms without fear, but the criteria for panic disorder include both panic attacks and chronic apprehension about panic. Panic attacks are defined in Table 1.

In addition, people often develop patterns of association between the attacks and particular situations or activities from which escape might be difficult or embarrassing (e.g., traffic jams, meetings), or which may generate panicogenic sensations (e.g., hot, stuffy rooms, climbing stairs). Agoraphobia is the avoidance of situations where the person fears having a panic attack. Formal diagnostic criteria are listed in Table 2.

TABLE 1. WHAT *are* PANIC ATTACKS?

Panic attacks are discrete periods of intense fear or discomfort in which four or more of the following symptoms develop abruptly and reach a peak within 10 minutes.

- 1 Palpitations, pounding heart, or accelerated heart rate
- 2 Sweating
- 3 Trembling or shaking
- 4 Sensations of shortness of breath or smothering
- 5 Feelings of choking
- 6 Chest pain or discomfort
- 7 Nausea or abdominal distress
- 8 Dizziness, unsteadiness, lightheadedness or faintness
- 9 Derealization or depersonalization
- 10 Fear of losing control or going crazy
- 11 Fear of dying
- 12 Paresthesias
- 13 Chills or hot flashes

(Adapted with permission from: DSM-IV. ©1994. American Psychiatric Association, p. 395)

TABLE 2. DIAGNOSTIC CRITERIA for PANIC DISORDER WITH or WITHOUT AGORAPHOBIA

Both 1 and 2:

Recurrent unexpected panic attacks (at least two)

At least one attack followed by one or more of the following, and lasting for at least one month:

Persistent concern about additional attacks.

Worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, going crazy).

A significant change in behavior related to the attacks.

The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., hyperthyroidism).

The panic attacks are not better accounted for by another mental disorder, such as Social Phobia (occurring on exposure to feared social situations), Specific Phobia (on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (an exposure to dirt in someone with an obsession about contamination), Post-Traumatic Stress Disorder (in response to stimuli associated with a severe stressor), or Separation Anxiety (in response to being away from home or close relatives).

Agoraphobia may or may not be present. If Agoraphobia is not present, diagnosis is Panic Disorder without Agoraphobia, 300.01. If present, diagnosis is Panic Disorder with Agoraphobia, 300.21.

Agoraphobia is the fear of being in places or situations from which escape is difficult because of physical (being on a bridge) or social, i.e. embarrassment (standing in line, sitting in a meeting) constraints, or where help is not readily available in the case of a panic attack. The situations are avoided or endured with fear. Typical agoraphobic fears are being in crowds, traveling by car or public transportation, going out without a companion, etc.

(Adapted with permission from: *DSM-IV*. ©1994. American Psychiatric Association, p. 396 & 402.)

The nature and pattern of panic attacks vary considerably. Many patients report their most severe attacks early in the disorder, after which they are more troubled by chronic apprehension, with occasional panic or limited symptom attacks (attacks of fear with fewer than four associated symptoms). Others may experience moderately intense attacks with regular frequency for months on end. Still others have short periods of very frequent attacks, even several daily, interspersed with long periods with few or no attacks. Untreated panic disorder appears to have a chronic course, often waxing and waning over the years.

Throughout this guideline, we will use the terms "mild," "moderate," and "severe" agoraphobia. The distinction between the various levels of avoidance is difficult to make. As a result, the DSM-IV dropped it from the previous DSM version. However, lacking an easy-to-use current measure that differentiates among the levels, the DSM-III-R definitions* can serve as a rough guide for the clinician.

MILD AGORAPHOBIA: There is some avoidance or endurance with distress, but a relatively normal lifestyle. The person can travel unaccompanied when necessary, such as to work, but avoids other travel alone.

MODERATE AGORAPHOBIA: There is a constricted life-style, i.e., the person can leave the house alone, but only a few miles' distance.

SEVERE AGORAPHOBIA: The person is nearly or completely housebound or unable to leave the house unaccompanied.

* Adapted with permission from the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, revised*. © 1987. American Psychiatric Association.

Biological theories postulate physiological dysregulation as the basis for panic attacks and panic disorder, e.g., hypersensitive carbon dioxide receptors in the brain stem, dysregulation of the noradrenergic system (especially in the locus ceruleus), the serotonin, benzodiazepine/GABA, cholecystokinin, and adenosine systems. Cognitive models pertain to the maintenance of the disorder rather than the cause of the original panic attack. The most prominent cognitive theory of panic holds that catastrophic misinterpretations of somatic sensations underlie recurrent panic attacks.

As intriguing as much of the biological research has been, there is enough conflicting evidence to argue against a singular biological substrate of panic disorder. The etiology is likely to be multifactorial, i.e., there is contribution of several or many genes as well as environmental factors. Thus, while panic attacks may be phenomenologically similar across patients, *the underlying biological mechanisms are likely to be heterogeneous. Yet more importantly, none of the biological contributions are dangerous, i.e., correspond to the catastrophic fears expressed by the patients.*

One of the most influential psychobiological formulations states that some people have a biological vulnerability to respond to stress with an episode of biological dysregulation (a panic attack). For panic disorder to manifest, the person must also have psychological vulnerabilities, such as issues about unpredictability and uncontrollability. Thus, fears of being out of control are very common, as is the perception that one cannot cope with discomfort. The latter can lead to high anxiety sensitivity, i.e., a tendency to view unpleasant sensations and affect as threatening.

As said earlier, agoraphobia occurs often as a complication of panic disorder, where the person avoids situations for fear of panic attacks. Avoidance can take one of three forms:

Avoidance of situations

Escape from situations when anxiety or panic occur

Reliance on safety signals (e.g., carrying medications, water at all times) or safety behaviors (e.g., holding onto the shopping cart for fear of fainting, trying to control one's thoughts to prevent insanity) in a situation to ensure that the feared catastrophe will not occur

Different studies have found that two to four screening questions can identify cases with fairly high sensitivity and specificity. Such screening questions could be included in health appraisal questionnaires, as part of certain medical exams, and on psychiatry screening questionnaires. Using the following screening questions (see Table 3), a cutoff score of 11 correctly identifies panic disorder patients from other anxiety patients with an accuracy of 75%.

The evaluation of panic disorder should include several elements to select the right treatment and to evaluate the outcome of treatment/s provided.

Medical conditions can be ruled out using a history, physical examination, and any appropriate laboratory tests. This also reassures

the patient. Conditions that mimic panic attacks include thyroid dysfunction, pheochromocytoma, cardiac arrhythmias, vestibular dysfunction, seizure disorder, irritable bowel syndrome, asthma, obstructive pulmonary disease, polycythemia, migraine, or lupus.

Assess the Urgency for Treatment

Factors affecting urgency include risk of loss of job or primary relationships, interference with necessary medical procedures, jeopardy to the welfare of another (particularly children), medical complications secondary to avoidance behavior, and the acute, rapid generalization of avoidance behavior. *Note that panic attacks themselves are not emergencies and, for the patient's sake, should not be responded to as such.* The patient's perception of loss of control should be distinguished from any actual loss of control. Functional impairment is a more critical variable to address.

Sixty-five percent of panic patients present with a comorbid Axis I diagnosis, especially other anxiety disorders and depression. Some comorbid anxiety disorders might be addressed in the context of treating the panic disorder, others may be treated subsequently. Many patients become depressed as a consequence of their panic disorder. In these cases (unless the depression is severe or there is suicidal ideation), the panic disorder should be treated first. Additional questions in regard to comorbidities for the clinician to answer include (a) which pattern of symptomatology is dominant at the moment, and (b) which set of problems does the patient define as high priority.

Panic may also occur within the context of a substance abuse disorder. Substance abuse may be primary, leading to the onset of panic attacks and panic disorder. Psychoactive substances that can trigger panic attacks are psychostimulants, cannabinoids, hallucinogens, PCP, etc. Withdrawal reactions from sedative-hypnotics may also trigger panic attacks. Many people report using alcohol as an anxiolytic. Such use can lead to the self-perpetuating cycle of use,

TABLE 3. BRIEF PANIC DISORDER SCALE

Please rate each item by circling one of the five phrases for each statement.

	Very Little	A Little	Some	Much	Very Much
It scares me when I feel shaky.	0	1	2	3	4
It scares me when I feel faint.	0	1	2	3	4
It scares me when my heart beats rapidly.	0	1	2	3	4
It scares me when I become short of breath.	0	1	2	3	4

(Apfeldorf WJ, Shear MK, Leon AC, & Portera L. 1994. A Brief Screen for Panic Disorder. *Journal of Anxiety Disorders*, 8(1), 71-78.)



withdrawal-induced aggravation of symptoms, followed by further use and abuse. Substance abuse among our Health Plan members should be treated within Chemical Dependency Services, and if particularly severe, may require the more intensive approach of the Chemical Dependency Recovery Program (CDRP).

TREATMENT

As with many disorders, rapid access to specialized treatment can be a significant factor in treatment outcome. When treatment is provided early in the course of panic disorder, especially if there is no significant avoidance behavior, it may shorten the duration of the condition and forestall the development of avoidance and other complications. The list of treatment goals in Table 4 is derived from the clinical literature and from Kaiser clinicians working with panic patients. The goals are ambitious and may be achieved only in a limited way.

COGNITIVE-BEHAVIOR THERAPY (CBT)

Once a decision is made to proceed with treatment of panic disorder, the next question is whether to employ a psychotherapeutic or pharmacologic intervention, or both.

There is increasing evidence that the effectiveness of CBT is hampered by combining it with medications, and medication may increase the risk of relapse. Blocking somatic sensations of anxiety and reducing the physiological fluctuations that may trigger panic can interfere with the interoceptive exposure that has been demonstrated to be an important component of CBT.

The National Institute of Mental Health Multi-Center Comparative Study of Panic Disorder is an excellent research study comparing CBT with imipramine, separately and in combination. This study involved patients with a primary diagnosis of panic disorder with no or mild agoraphobia. While the results showed that the mono treatments were equally effective (with no advantage to combining them) in the acute (3 months) and maintenance phases (6 months), the follow-up six months later (i.e., *no* treatments) showed significantly better results for those having received CBT alone. Hence, there was no advantage to combining CBT and the antidepressant. *In fact, although CBT + imipramine was superior to the mono treatments at the end of maintenance, the combination produced the highest relapse rates at follow-up.* CBT did not mitigate relapse after medication discontinuation (Barlow, Gorman, Shear, et al., 2000).

Although this study involved imipramine, a tricyclic antidepressant, there is reason to believe that the SSRIs would yield similar results. This can be concluded in part because imipramine *was* effective during its application, but the effect was not sustained upon discontinuation. In other words, factors other than those of the medication itself might have led to the loss of effectiveness.

At the present time, then, the evidence in the literature overwhelmingly indicates that CBT is the treatment of choice. The cognitive-behavioral treatment should not merely be aimed at symptom reduction but at achieving marked cognitive change, i.e., *cessation of fear of panics.*

TABLE 4. TREATMENT GOALS

- Reduction or elimination of the frequency and/or intensity of panic attacks.
- Reduction of fear of panic and other anxiety sensations.
- Increased self-efficacy (i.e., sense of coping ability).
- Reduction of anticipatory anxiety.
- Reduction of avoidance behavior.
- Increased levels of functioning (e.g., work, family, social).
- Reduced panic-related utilization of medical services (e.g., primary or specialty care, Emergency).
- Reduced need of Psychiatry services.
- Reduced use of medications (especially benzodiazepines).
- Reduced secondary problems (especially depression and substance abuse).
- Increased patient satisfaction.

It may be useful to share aspects of this list with patients at the beginning of treatment to broaden their perspective, since so often their focus is solely on the elimination of panic attacks.

Group CBT is recommended when possible, for several reasons. There is evidence that group CBT is at least as effective as individual CBT, and possibly more so. The group can reduce some of the shame many panic patients experience by helping them realize that they are not alone. It can provide modeling, inspiration, and reinforcement from other group members. For some patients, a group can be a useful exposure situation. The group format lends itself well to the many educational components of CBT. Finally, groups can be more cost-effective than individual therapy.

When possible, CBT without medications is recommended. We encourage the use of medications only in cases of moderate to severe impairment. If the patient is not already on medication, has panic disorder with no more than mild-to-moderate-range agoraphobia, has no history of unsuccessful CBT and is not insisting on medication, then CBT alone has a good chance of success.

■ ELEMENTS OF CBT

The NIMH study mentioned above revealed *the need to adhere closely to the prescribed CBT protocol*. This protocol consists of the following components:

■ PSYCHOEDUCATION

The first component of any psychosocial treatment of panic disorder includes information about the nature of anxiety, panic attacks, and panic disorder. The model presented on the etiology should include biological and psychological predisposing and maintaining factors as well as possible major stressors, all contributing to the actual manifestation of attacks. It could also include some reassuring comments about the lack of relationship between panic and feared catastrophic events, such as heart attacks and syncope.

■ BREATHING RETRAINING

Historically, relaxation training of some sort has been an important component of the behavioral treatment of anxiety. *While relaxation is generally anxiolytic, it does not add specific benefits in the treatment of panic.*

Breathing retraining is more relevant for panic patients. They learn to breathe diaphragmatically and slow down their rate of breathing to ten breaths per minute or less. It should be first practiced at home and gradually applied when coping with anxiety and panic. This technique is particularly helpful to counteract hyperventilation, which often occurs during panic attacks. Also, it can indirectly lead to lowering arousal, allowing the patient to perceive some sense of control.

If taught, it is important to monitor that patients *not use diaphragmatic breathing as a distraction from the sensations of anxiety*. Used in this way, it may actually be

countertherapeutic, and *it should not be used to prevent the experience of interoceptive exposure*.

■ COGNITIVE RESTRUCTURING

Cognitive restructuring refers to a variety of techniques that are intended to address beliefs that anxiety, once initiated, will persist indefinitely and increase in intensity; that the symptoms of anxiety actually signal some imminent catastrophe; and that the only way to prevent disaster is to avoid or escape the feared sensations. Patients who persist in harboring the belief that panic attacks are dangerous or represent signs of illness do not do well after treatment.

Cognitive techniques employed include identifying anxious cognitions and distortions about the probability of threat and catastrophizing about the ability to cope. These distortions may be corrected by challenging the erroneous automatic thoughts, and by examining the evidence via Socratic dialogue.

■ INTEROCEPTIVE EXPOSURE

Interoceptive exposure, also called desensitization, is a major component of CBT for panic disorder. Since panic disorder is essentially a fear of certain kinds of sensations, exposure should always include interoceptive cues (internally perceived sensations that are associated with panic, e.g., increased heart rate, dizziness, or shortness of breath). Patients engage in a series of exercises that elicit panic-like sensations, e.g., hyperventilation, spinning, breathing through a narrow straw, etc. These exercises are the repeated until the sensations no longer elicit anxiety. In interoceptive exposure, it is important that the patient does not engage in any subtle avoidance, such as distraction or premature relaxation.

These in-office exposures are subsequently assigned as tasks to be conducted at home and various other places. Patients are also asked to engage in so-called "naturalistic" exposures, i.e., real life activities that elicit the feared somatic sensations (e.g., saunas, caffeine consumption, exercising, etc.). *As much as practically possible, these sensations should also be brought on in the actual agoraphobic situations.*

■ IN VIVO EXPOSURE (IN AGORAPHOBIA)

In vivo exposure involves having patients seek out feared situations, i.e., exposure to real life. In vivo exposure is the best treatment for agoraphobia. *In spite of successful elimination of panic attacks, even mild agoraphobia does not remit on its own.*

Exposure trials should be as prolonged as possible, with from one to two hours for each trial often being recommended. Trials should be repeated with regular frequency: an absolute minimum of three exposure sessions per week is recommended, but daily exposure sessions are much more effective (for a minimum of 6-7 hours

exposure a week). Finally, exposure should include *all* avoided situations, such as driving, long lines, supermarkets, and similarly avoided circumstances. Occasional accompaniment by a therapist or coach appears to increase the chances of compliance and effectiveness of the procedure.

It should be noted that many popularized approaches to managing panic rely heavily on the use of distraction techniques. These techniques are contraindicated and we do not recommend them. Even more to the point, the elimination of safety signals and safety behaviors leads to greater change in catastrophic beliefs and reduction of fear than exposure alone.

■ Relapse Prevention

In the case of panic disorder, relapse is more likely to occur under the following conditions: Increased stress, illness or excessive fatigue, and lack of completion of avoidance hierarchies. When relapse occurs, patients sometimes think of themselves as having lost ground. This can lead to discouragement and abandonment of useful self-coping methods. Maintaining gains after completion of CBT thus requires active work by the patient. Maintenance planning involves holding onto gains, continuing with exposures, and dealing with possible relapse.

A time-honored practice involves either tapering the last treatment sessions over increasing intervals, or providing booster sessions at regular intervals after formal treatment is terminated. Patients should be allowed to repeat group therapy at the clinician's discretion.

■ Enhancement of CBT

■ Treatment of Panic Disorder with CBT

A comprehensive CBT treatment group usually consists of a minimum of ten sessions for patients with panic disorder with no or mild agoraphobia. For those with more significant agoraphobia, commonly 15 sessions are reported in the literature. Although some studies have shown good results with fewer sessions, 10-15 sessions reflect the standard at this time. Especially if treatment length is short, time spent on cognitive restructuring and interoceptive and in vivo exposures results in better outcomes than on, e.g., breathing.

A clear distinction must be made between psychoeducational classes and therapy groups for patients with panic disorder. These patients need *specialized treatment* and most do not benefit significantly from psychoeducational classes. Hence, classes, on their own, do *not* constitute treatment for panic disorder.

■ Involvement of Significant Others

Several studies have demonstrated the added value of including spouses in the behavioral treatment of panic disorder with agoraphobia. Some of these studies found a benefit from simply including spouses in treatment sessions. Clinicians experienced with

this population also know that spouses, other family members and friends may be impacted by the limitations imposed by moderate to severe agoraphobia.

■ HIGH-TECHNOLOGY AIDS TO TREATMENT

Computers are likely to be used increasingly in the future. Exposure, the cornerstone of phobia treatment, is often difficult to carry out. Virtual reality consists of a three-dimensional virtual world that mimics real-world places and experiences. This medium has been applied successfully in phobia treatment and its use is likely to expand. Virtual reality allows stimuli to be controlled so that segments can be repeated over and over more easily than in real life. However, the ultimate goal is real life exposure.

■ Treatment Response or Failure

Between 50% and 87% of patients will get some meaningful benefit from the treatment recommended above. The lower improvement rates are seen in those with moderate to severe agoraphobia. Benefits should include a reduction in the frequency and intensity of panic attacks, a reduction in anxiety, decreased avoidance behavior, and improved functional status and sense of well-being. In general, *some positive response should be seen within six to eight weeks of initiating CBT*. If there is no response at all to CBT within this time frame, the patient should be evaluated for treatment adherence or re-evaluated for diagnosis. Patients may need another trial or format of CBT, and a referral for medications should be considered.

■ For Whom Are Treatments Not Effective or Failure?

Emotion-focused therapy was developed as a systematic form of psychodynamic therapy that explores directly panic attacks and other unexplained emotional reactions with an attempt at seeking a greater sense of control. Subsequent research on its efficacy showed that it is not effective as a main treatment for panic disorder. Other forms of psychotherapy, including EMDR, have neither shown efficacy nor constitute standard-of-care treatment for panic disorder.

■ Medication Treatment

The efficacy of antidepressants and benzodiazepines in treating symptoms of panic disorder has been established in controlled clinical studies. Medications have been shown to be effective in reducing the frequency and intensity of panic attacks, improving impaired social/work functioning, and treating co-morbid depression. Less well established is the extent of their influence on reducing phobic avoidance and anticipatory anxiety.

There are important issues to consider prior to initiating pharmacotherapy. First, *clinical experience and judgment form the basis of most decision-making in the pharmacotherapy of panic disorder.* Second, while clinical judgment should remain the basis for decision-making, the prescribing physician needs to be *informed about the extensive body of clinical research that addresses various aspects of treatment.* Unfortunately, most studies

examining the efficacy of medications in treating panic disorder have focused on initial phases of treatment (up to 3 months).

An example of how clinical research may alter clinical decision-making concerns the interplay of medications and CBT in treating panic disorder. The recent NIMH multi-center study comparing outcomes of CBT vs. imipramine vs. CBT + imipramine in treating panic disorder with no or mild agoraphobia clearly showed that CBT alone yielded better results at 6 months follow-up than either imipramine alone or CBT + imipramine even though initial responses to all three treatments were equivalent (Barlow et al., 2000). Note that this study included patients with all comorbidities, including major depression and personality disorders. Excluded (besides the patients with moderate to severe agoraphobia) were those with current or recent suicide risk, bipolar disorder, psychosis, significant substance abuse, or significant medical illness. The results of this study strongly suggest that TCAs and perhaps all antidepressants may impair the efficacy of CBT and that *CBT alone is the first line treatment for panic disorder without moderate to severe agoraphobia*. This study serves as a cautionary reminder that although clinical judgment is invaluable, it is also fallible and should be informed by clinical research whenever possible.

Elements of Pharmacotherapy

CHOOSING TO TREAT PHARMACOLOGICALLY

Three considerations should be taken into account before deciding to use medications:

- Degree of functional impairment. Severe panic attacks, severe avoidance, or severe anticipatory anxiety often warrant pharmacotherapy.
- Patient's ability to tolerate symptoms. Although many authors recommend medicating when panic is frequent or intense or there is significant anticipatory anxiety, the patient's ability to tolerate discomfort is an important factor in recovery and should be reinforced. Thus if the patient is receiving CBT and is willing to postpone pharmacotherapy, waiting six to eight weeks before starting medication is warranted.
- Presence of comorbid psychiatric conditions. An example is depression, especially if symptoms are severe or if demoralization and suicidal ideation are present. These factors can not only interfere with other aspects of treatment, such as CBT; they may also lead to further deterioration if left untreated.

THE CASE OF SUBSTANCE ABUSE

Significant alcohol abuse, as well as the use of illegal substances, complicates psychopharmacological treatment. Since these patients are more prone to abuse benzodiazepines, these medications should be avoided except where needed for detoxification. Because of the risk of alcohol relapse, even antidepressants should be used with caution.

For instance, interactions of alcohol with TCAs can result in serious consequences such as a lowered seizure threshold. For this reason, the use of medications should be entertained only if the patient agrees to make use of additional therapeutic and social supports that promote abstinence and sobriety.

It should be noted that some patients may maintain sobriety for a period of time but fail to respond to panic treatments, including CBT and multiple antidepressant trials. If the risk factors of the particular case (including the possibility for increased suicide risk secondary to prolonged uncontrolled panic) warrant, it may be worth considering long-term treatment with benzodiazepines. If such an option is chosen, it is important that sufficient social support and monitoring capability be available. While we know that such a decision may be controversial, the pros and cons should be actively considered and documented rather than being ruled out automatically.

The criteria for considering acute pharmacotherapy are summarized in Table 5.

TABLE 5. CRITERIA for CONSIDERING ACUTE PHARMACOTHERAPY

- Moderate to severe functional impairment, coupled with urgency to remediate the impairment
- Patient inability to tolerate symptoms
- Comorbidities such as clinically significant depression, demoralization, suicidal ideation
- Secondary alcohol abuse

THE INTERFACE BETWEEN PHARMACOTHERAPY & CBT

When pharmacotherapy is clearly indicated, e.g., in more severe agoraphobia, significant comorbidities, and/or functional impairment, we strongly encourage physicians to consider concurrent referral for CBT. If the patient is able to engage in CBT, there may be a better outcome than with medications alone. If not introduced earlier, CBT may facilitate discontinuation from medications, because reducing anxiety sensitivity (fear of anxiety symptoms) during discontinuation is crucial. Benzodiazepines should usually not be offered concurrently with CBT after about the first month of CBT.

Classes of Medications

Several classes of antidepressants (SSRIs, TCAs and MAOIs) and benzodiazepines have documented efficacy in treating symptoms of panic disorder. Clinical experience suggests that all four classes are roughly comparable in efficacy. While the choice of medication will depend on a number of factors, *SSRIs are probably first line agents for most patients with panic disorder who are prescribed medications*. Except for their higher rates of sexual side effects, the

are well tolerated by most patients and they generate little or no cardiovascular or anticholinergic side effects. In addition, they are much less lethal in overdose. Benzodiazepines may be first line agents in patients requiring immediate relief of symptoms, especially if the symptoms are severely compromising the patient's ability to function. (See *Practice Guideline for the Treatment of Patients with Panic Disorder*, 1998, for numerous references.)

ANTIDEPRESSANTS

All antidepressants reduce the intensity and frequency of panic attacks, reduce anticipatory anxiety, and can treat co-morbid depression. Classes, types, and dose levels of antidepressants are given in Table 6.

■ SSRIs

Selective serotonin reuptake inhibitors (SSRIs) currently available are: paroxetine, fluoxetine, fluvoxamine, citalopram, and sertraline. Clinical studies have documented the efficacy of all five with panic disorder.

The major side effects of SSRIs are sexual dysfunction, gastrointestinal symptoms, headache, nausea, irritability, insomnia, drowsiness, and tremor. Abrupt discontinuation can trigger a withdrawal syndrome marked by headache, dizziness, nausea, incoordination, and irritability.

As is the case with all antidepressants that are effective in treating panic disorder, SSRIs frequently cause an initial increase in anxiety. The initial dose should therefore be 1/4 to 1/2 of the initial dose used to treat depression. Although some patients respond to doses lower than those typically used to treat depression, most patients require standard antidepressant doses.

■ TCAs

Imipramine has long been the medication gold standard in clinical studies of panic disorder. Other tricyclic antidepressants (TCAs) have been assumed to be as effective as imipramine but only clomipramine has been shown to be so.

The major side effects of TCAs are anticholinergic side effects, orthostatic hypotension, sedation, weight gain, and sexual dysfunction. Patients with narrow-angle glaucoma, prostatic hypertrophy, or cardiac conduction disturbances should be treated with other agents. Elderly patients who are at higher risk for falls and anticholinergic confusional states are also better treated by other agents. Because of their propensity to cause cardiac arrhythmias in overdose, TCAs have a low therapeutic index and should be used cautiously in suicidal patients.

Treatment with TCAs is initiated with doses substantially less than those used to initiate treatment for depression (10 mg imipramine qd for panic disorder versus 25-50 mg qd for depression). Typical doses producing good therapeutic effect are 100 to 300 mg/day.

■ MAOIs

Clinical experience holds that monoamine oxidase inhibitors (MAOIs) are superior agents for relieving symptoms of panic disorder, but this observation has never been demonstrated by controlled clinical studies. MAOIs can produce a number of problematic adverse reactions, notably hypertensive crises and the serotonergic syndrome that necessitate careful monitoring on the part of the prescribing physician. There are dietary and medication restrictions for patients. For these reasons, MAOIs are best used as *agents of last resort* by clinicians familiar with their use.

A few studies have been or are being conducted with the reversible monoamine oxidase-A (MAO-A)-inhibitors (also called RIMAs), such as moclobemide and brofaromine. These agents do not require a low tyramine diet as do the MAOIs. Side effects are insomnia, headache, and nausea. Studies have shown that these medications are effective in treating panic disorder. However, dropout rates tend to be high, more so for brofaromine than moclobemide.

■ OTHER ANTIDEPRESSANTS

Clinical studies have demonstrated the efficacy of venlafaxine (*Effexor*) and nefazodone (*Serzone*) in treating symptoms of panic disorder. Trazodone may benefit some patients with panic disorder but the only controlled clinical study of trazodone did not find it to be as effective as imipramine. Bupropion has not been shown to be effective in treating panic symptoms.

BENZODIAZEPINES

Compared to the various antidepressants, these medications have an immediate anxiolytic effect and high patient acceptance because of their mild sensory effects. *Extreme caution should be used if prescribing to anyone with a history of substance abuse or with a personality disorder. Although other panic patients do not tend to abuse these drugs, many tend to depend on them to avoid panic-related sensations and this dependence is counter-therapeutic.*

Numerous studies have documented the efficacy of alprazolam in the treatment of panic disorder, especially when dosed in the range of 4-6 mg/day. Clonazepam, lorazepam, and diazepam have also been shown to be effective in controlled clinical trials. Use, type, and dose levels of benzodiazepines are given in Table 7.

The major side effects of benzodiazepines are impaired motor coordination, sedation, slurred speech, and fatigue. Memory function has been found to be impaired as a result of benzodiazepine treatment and persists up to two months post-treatment. Use of benzodiazepines in the elderly must take into account their higher susceptibility to these side effects and possible consequences (risk of falls, confusion, impaired driving).

TABLE 6. PHARMACOTHERAPY of PANIC DISORDER: ANTIDEPRESSANTS

PHARMACOLOGICAL ACTIVITY PROFILE	CLASS	MEDICATION	STARTING DOSE	TARGET DOSE* (RANGE)	COMMENTS
Serotonin (5HT) Uptake Inhibition	SSRIs	Fluoxetine (Prozac)	5 mg q am (or 2 mg q am of elixir)	20 mg q am (10 to 60 mg q am)	May be too activating for some patients
		Fluvoxamine (Luvox)	25 mg bid	50 mg bid (25 to 100 mg bid)	
		Paroxetine (Paxil)	10 mg q am	20 mg q am (10 to 50 mg q am)	
		Citalopram (Celexa) Currently Non-formulary	10 mg q am	20 mg q am (10 to 40 mg q am)	
		Sertraline (Zoloft) Currently Non-formulary	25 mg q am	100 mg q am (50 to 200 mg q am)	
Combined 5HT and Norepinephrine Uptake Inhibition	TCAs**	Imipramine (Tofranil)	10 mg q am	150 mg q hs (50 to 300 mg q hs)	Use cautiously in geriatric patients
		Clomipramine (Anafranil)	12.5 mg q am	75 mg q d (25 to 150 mg q d)	Use cautiously in geriatric patients
	Other	Venlafaxine*** (Effexor)	25 mg bid	75 mg bid (37.5 to 150 mg bid)	Monitor blood pressure, can cause hypertension
5HT Uptake Inhibition and 5HT ₂ antagonist		Nefazodone (Serzone)	50 mg bid	150 mg bid (100 to 200 mg bid)	Inhibits metabolism of many medications. May require dose adjustment

*Target dose in the elderly is 50% of the target dose listed.

**Relative extent of uptake inhibition of 5HT and Norepinephrine varies with the specific TCA.

***Effexor may be converted to 100 to 150 mg qd for once-a-day dosing once patient is stabilized.

TABLE 7. PHARMACOTHERAPY of PANIC DISORDER: BENZODIAZEPINES

USE	MEDICATION	STARTING DOSE	TARGET DOSE (RANGE)	COMMENTS
Primary Control of Panic Symptoms	Clonazepam (Klonopin)	0.5 mg bid	1 mg bid (0.5 to 2 mg bid)	
	Lorazepam (Ativan) Currently Non-formulary	0.5mg bid to tid	4 mg qd in divided doses (2 to 8 mg qd in divided doses)	
	Alprazolam (Xanax)	0.25 mg tid	2-3 mg qd in tid to qid dosing (2 to 6 mg q d in tid to qid dosing)	Breakthrough and rebound symptoms common. Tapering often difficult, consider changing to clonazepam and then taper.
Adjunctive Use to Block Anxiety, Not Panic	Clonazepam (Klonopin)	0.25 mg qd	0.5 mg qd (0.25 mg qd to 0.5 mg bid)	Confine use to time it takes for antidepressant to take effect and less than 4 weeks total. Do not prescribe as prn.
	Oxazepam (Serax)	10 mg qd	10 mg tid (10 mg tid to 60 mg bid)	Same as per clonazepam.

Formidable problems of dependence, withdrawal symptoms, rebound anxiety, and relapse occur in the majority of patients tapered off benzodiazepines. *Relapse rates are high and can approach 100%.* Though discontinuance symptoms are greatly diminished with *very gradual* taper, they may still be severe in some patients. It has been reported that continuous, long-term use of benzodiazepines is related to worse outcome than no medication use or use of antidepressant only. If benzodiazepine treatment is prescribed, CBT administered to overlap with medication taper and beyond discontinuation helps decrease relapse.

Benzodiazepines can be useful adjunctive agents during the initiation of antidepressant treatment of panic disorder. Short-term use of benzodiazepines can reduce the anxiety associated with panic and minimize the intensity of the activation symptoms that occur upon starting an antidepressant. The goal is to decrease anxiety to tolerable levels, not to suppress all symptoms of panic. *Be absolutely clear with the patient at the beginning of pharmacotherapy that the use of the benzodiazepine will be time-limited with an initial two-week prescription, and a total duration of no more than approximately four weeks. Benzodiazepines are contraindicated as a treatment concurrent with CBT after approximately the first month of CBT, if not sooner. Furthermore, to avoid fostering psychological dependence, benzodiazepines should never be prescribed as prn medications.* Time-limited b.i.d. or t.i.d. dosing will minimize the

development of psychological dependence and facilitate discontinuation.

Case reports have suggested that carbamazepine and valproic acid may be efficacious treatments for panic disorder. The only controlled study of carbamazepine failed to find any benefit over placebo. Valproic acid was more effective than placebo in one controlled study. Gabapentin has been reported to decrease phobic avoidance in patients with social phobia. Its efficacy in panic disorder remains to be determined. In general, the use of these agents for panic disorder is not supported by the literature.

Beta-blockers, anti-histamines, and buspirone are *not* effective in treating panic disorder.

The acute phase lasts approximately 12 weeks. If adequate response is attained by 12 weeks, the patient should move to maintenance phase.

Treatment goals consist of reducing the frequency and intensity of panic attacks and decreasing the anxiety associated with panic attacks.



As reported earlier in this guideline, the best study to date indicates that CBT is the first-line treatment of choice, at least for panic disorder with no or mild agoraphobia. Should medication be employed to treat patients, antidepressant treatment should be initiated and optimized based on response and side effects. At the beginning of the acute phase the patient needs close monitoring, preferably every one to two weeks. The patient should be told to expect increased jitteriness and agitation from the outset; prompt support and reinforcement that this is normal and short-lived will help maintain patient cooperation. If the patient does not tolerate the side effects, then the dosage can be reduced for a time and increased more gradually as tolerated, or treatment can be supplemented with a benzodiazepine as previously discussed. If necessary, the antidepressant can be changed. If the antidepressant is tolerated, some response should be observed in six to eight weeks. Patients with adequate responses at twelve weeks begin the maintenance phase.

MAINTENANCE PHASE

- The maintenance phase may last anywhere from 3-18 months following the 3 months of acute phase treatment.
- Treatment goals consist of consolidating the gains of the acute phase and minimizing residual symptoms and risk of relapse.

Patients with a long history of panic who relapsed after termination of a previous pharmacologic intervention, or who have not progressed well during CBT, are likely candidates for a maintenance regimen of medication.

A common clinical strategy is to consider a trial of dose reduction after three to six months in order to achieve the smallest needed effective dose. Once effective anti-panic medication regimens are titrated, dosing is usually fairly stable over time. Patients with good responses should be maintained at least six, often twelve months before discontinuation of medications is considered. If attempts at discontinuation are unsuccessful in spite of slow and controlled weaning, long-term maintenance use of anti-panic medication should be considered. *Many clinicians argue that the continued presence of avoidance behavior indicates the need for continued pharmacotherapy, although a good dose of exposure therapy with an experienced clinician should be considered as well if it has not been done.*

Patients with significant residual symptoms, including avoidance, and/or ongoing functional impairment should be maintained for as long as conditions warrant. Given the chronic and relapsing nature of panic disorder, maintenance pharmacotherapy is not uncommonly needed, with possible further trials of dose reduction at later times. An option to be considered when the patient has difficulty with discontinuation, even if he or she went through a course of CBT earlier, is a new course of CBT planned to coincide with tapering and discontinuation. This requires a close collaboration between prescribing physicians and psychotherapists to achieve the best outcomes.

DISCONTINUATION PHASE

- Patients who have remission of symptoms for at least six months are candidates for discontinuation of medication.
- The goals are discontinuation of medication after tapering dosage and relapse prevention.

Relapse is not uncommon even when patients have responded well to pharmacotherapy. Relapse after medication discontinuation has often been attributed to state-dependent learning (i.e., gains made during drug state do not generalize to drug-free state). However, there is also evidence suggesting that patients who attribute their gains to pills (whether active medications or placebo), are more likely to relapse compared to those who attribute the gains to their own effort. Patients should be encouraged to undergo a trial of CBT to coincide with the discontinuation phase, if they have not yet done so.

Abrupt discontinuation of antidepressants and benzodiazepines should be avoided because of the likelihood of withdrawal symptoms. Antidepressants can be tapered over a four-week period by decreasing the dosage by 20-25% per week. As discussed earlier, relapse rates following discontinuation of benzodiazepines are extremely high; hence, tapering should occur at a slower rate, approximately 10% per week.

For an overview of medication management of panic disorder, see flow chart in Table 8.

CBT & PHARMACOTHERAPY: COMPARISONS OF OUTCOME & COST

When patients present to treatment centers, almost half of them express preference for pharmacotherapy. Patients need to be educated and guided according to outcome research. Thus, true informed choice includes education on short-term gains and long-term costs and benefits. A meta-analysis of treatment outcome in 43 controlled studies, and relative efficacy and cost-effectiveness of CBT and pharmacotherapy, are given in Tables 9 and 10, respectively.

CULTURAL CONSIDERATIONS

The presentation, conceptualization, and treatment of mental disorders vary across cultures. Differences in ethnic and cultural norms between patients and providers can result in inappropriate diagnoses and treatments. Potential problems stem from language barriers, differences in nonverbal communication, difference in perceptions of medical roles and responsibilities, and differences in how the disorder is explained.

Providers are encouraged to consult with informed colleagues, including champions of the Psychiatry Best Practices Cultural Competence Workgroup, and the *Cultural Diversity Resource Manual* issued in 1999. The latter includes four valuable booklets: *A Provider's Handbook on Culturally Competent Care for African American Population* (1999), *Latino Population* (1996), *Asian*

TABLE 8. OVERVIEW of MEDICATION MANAGEMENT of PANIC DISORDER

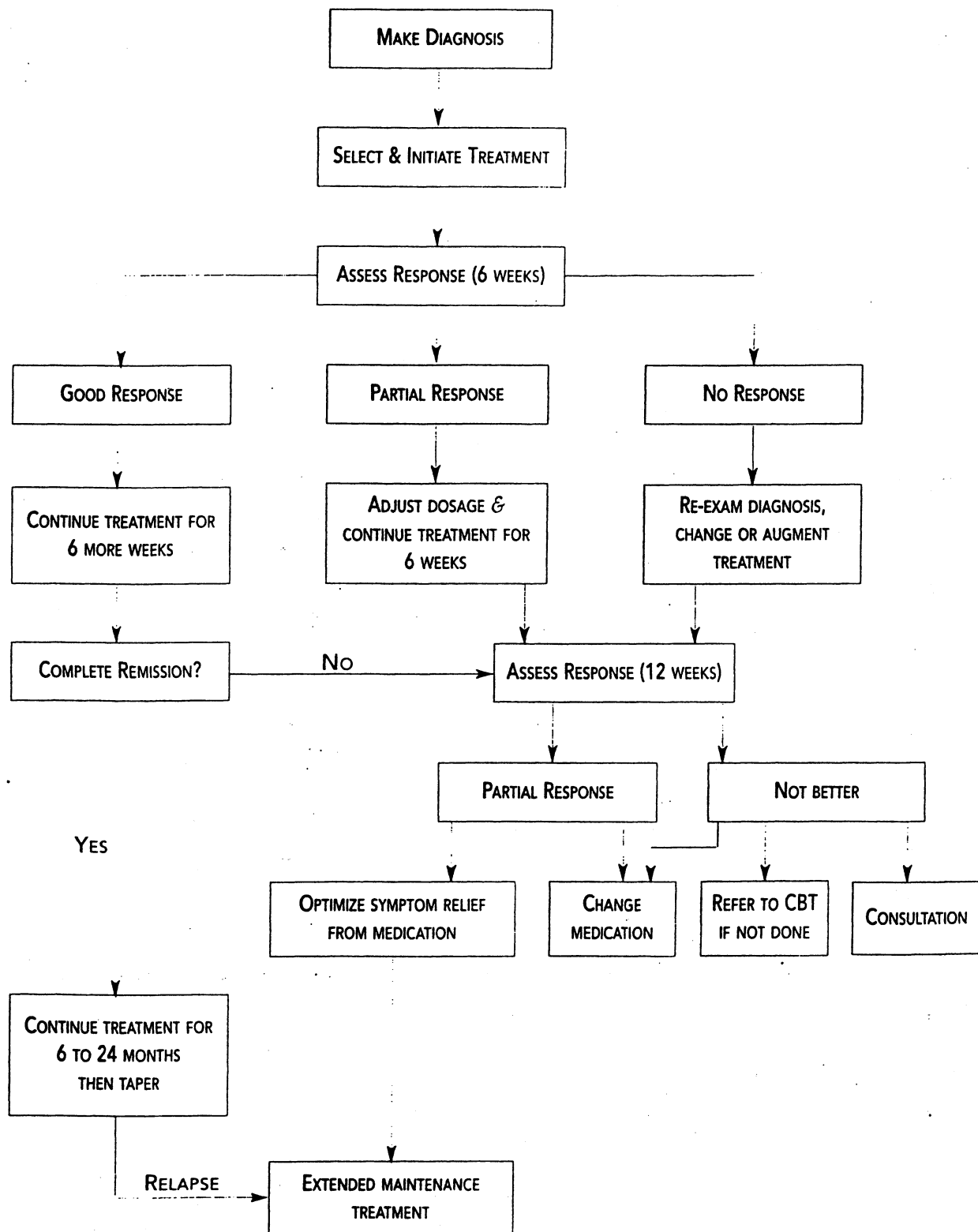


TABLE 9. TREATMENT EFFICACY: SUMMARY of RESEARCH FINDINGS

TREATMENT	EFFECT SIZE	EFFECT SIZE	% DROP-OUT
	POST-TREATMENT	F-U* (AT LEAST 6 MO.)	
CBT	0.68	0.06	5.6%
CBT: Cognitive Restructuring + Interceptive Exposure	0.88		
Pharmacotherapy	0.47	-0.46	19.8%
Antidepressant	0.55		
Benzodiazepine	0.40		
Combined Tx (Meds + Exposure)	0.56	-0.07	22.0%

* A negative number denotes slippage of treatment gains from post-treatment to follow-up; a positive number denotes that treatment effects are maintained. (Gould, RA, Otto, MW, & Pollack, MH. 1995. A meta-analysis of treatment outcome for panic disorder. *Clinical Psychology Review*, 15(8), 819-844.)

TABLE 10. COST of TREATMENTS

TREATMENT	1 YEAR		2 YEARS	
	# SESSIONS	\$	# SESSIONS	\$
Individual CBT	15	1350	15	1350
Group CBT	15	600	15	600
2.5 mg alprazolam	8	1020	12	1800
6.0 mg alprazolam	8	1776	12	3312
150 mg imipramine	8	576	12	912
20 mg fluoxetine	8	1872	12	3504

(Gould, RA, Otto, MW, & Pollack, MH. 1995. A meta-analysis of treatment outcome for panic disorder. *Clinical Psychology Review*, 15(8), 819-844.)

and Pacific Island American Populations (1999), and Lesbian, Gay, Bisexual and Transgendered Population (2000). Yet as much as information about cultures can guide us, there is danger in stereotyping people. When a patient presents to us, we are balancing racial and cultural background with the uniqueness of the individual.

African Americans tend to drop out of treatment prematurely, probably for the following reasons: (1) they do not seek help as readily, (2) there is greater use of informal services (prayer, family, clergy), (3) stigma and social embarrassment prevent them from

seeking psychiatric help, (4) physicians may refer them less to specialty services, and (5) they may not trust the medical establishment as readily due to past history of mistreatment and may be less open to use medications.

Latinos may refer to panic attacks as "nervios" or "susto." However, these terms are used for a host of other symptoms as well. A number of Latinos may consult folk healers, or "curanderos." They may believe they are possessed, or cast under a spell and seek healing.



Asians tend to under-utilize mental health services. Depending on the individual, seeking treatment may have been put off until symptoms have become acute. The fear of shame and being stigmatized is particularly strong in some Asian cultures, which place high value on saving face and thereby maintaining social status. There is evidence that people from Asian cultures have increased sensitivity to psychotropic medications. CBT is often a more acceptable form of treatment than insight-oriented psychotherapy.

Much of the psychological treatment of panic disorder occurs in group therapy. Bisexual and transgendered individuals may be very hesitant to be in group therapy, and groups vary in their composition and acceptance of others. Here, the therapist's modeling and leadership can play a large role.

SPECIFIC RECOMMENDATIONS

HIGHLIGHTS of EVALUATION

- For diagnosis, the DSM-IV (American Psychiatric Association, 1994) should be consulted. Not every patient who claims to have panic attacks has them and not everyone who has panic attacks has panic disorder. The extent of agoraphobic avoidance should be assessed, including the use of safety signals/safety behaviors.
- Differential diagnosis is important, especially distinguishing panic disorder from general medical conditions and from specific phobia, social phobia, and generalized anxiety disorder. Likewise, assessing comorbidities is crucial, especially depression, chemical dependence, and suicidal ideation.

DEPRESSION

It is important to ascertain whether depression is primary and the more distressing syndrome, or secondary to the panic disorder. In the latter case, barring suicidal ideation or significant impairment due to the depression, the panic disorder should be treated first. After this treatment, it can be ascertained if residual depression treatment is warranted. (For the treatment of depression, consult the *Clinical Practice Guideline for the Treatment of Depression in Psychiatry*, 2000.)

CHEMICAL DEPENDENCE

Chemical dependence may need to be treated first. However, if the patient is using the substance primarily to self-medicate for panic disorder, it is often best to run both treatments concurrently. In this case, the panic disorder treatment should be initiated only after a reasonable period of sobriety/drug-free state has been achieved.

- Rating scales to assess treatment outcome are exceedingly helpful in assessing the condition before and after treatment, regardless of type of treatment, CBT or pharmacotherapy.

The Panic Disorder Severity Scale–Self Report version is recommended (Shear, Spiegel, Houck, et al., 2000). The Panic Frequency and Intensity record (Zuercher-White, 1997, 1998) is simply a daily way of recording number of panics and anxiety associated with them.

HIGHLIGHTS of TREATMENT

- Specialized treatment for panic disorder and agoraphobia is essential and should be offered to every patient. The treatment consists of panic/agoraphobia-specific CBT or medications or a combination of both.
- Research has demonstrated that CBT has greater efficacy, especially in the long term. Furthermore, there is evidence now showing that at least when no or mild agoraphobia is present, CBT does better post-treatment than if ever combined with medications.

Psychoeducational Classes

Some people might benefit from psychoeducational classes focused on anxiety and panic. However, such classes traditionally emphasize breathing and other self-care coping skills that do not constitute the active treatment ingredients. *These interventions alone do not constitute "treatment" for panic disorder* and should not be portrayed as such in marketing materials or by the class instructor.

Cognitive-Behavior Therapy

- CBT for panic disorder/agoraphobia is aimed at overcoming the fear of panic attacks and avoided situations and must include these elements:
 - **PSYCHOEDUCATION:** This includes learning about anxiety and panic, the physiology of the fight/flight response and its relationship to panic attacks; and an etiological model of panic disorder consisting of a combination of biological, psychological, and stress factors. The panic experience is viewed as a response consisting of physiological sensations, cognitions, and behaviors.
 - **BREATHING RETRAINING:** Its purpose is to counteract hyperventilation and can be used as a coping skill for anxiety and panic. However, while many patients like this component the best, its value is increasingly being questioned, especially because it is countertherapeutic when used as a safety behavior to escape from interoceptive sensations.
 - **COGNITIVE RESTRUCTURING:** It is aimed at unlearning the beliefs that panic attacks are dangerous or that they may last indefinitely. The distorted beliefs are corrected via challenging automatic thoughts and examining the actual evidence.
 - **INTEROCEPTIVE EXPOSURE:** Exposure to feared internal panic sensations is achieved via the repetition of specific exercises that bring on sensations. These are then repeated in various settings, including agoraphobic situations, until the person no longer fears them. They are followed by naturalistic interoceptives.
 - **IN VIVO EXPOSURE FOR AGORAPHOBIA:** Patients systematically seek out feared and avoided situations. For agoraphobia treatment to be successful, patients must desensitize themselves to all avoided situations and remove all safety signals/safety behaviors.

- **RELAPSE PREVENTION:** Preparing for the return of panic attacks and phobic fears is crucial, since this is bound to occur sooner or later. Maintenance planning via the continued use of helpful coping skills (e.g., keeping track of and challenging negative automatic thoughts) ensures continued recovery.

Pharmacotherapy

- Pharmacotherapy should be considered in cases where:

- The distress of the condition is moderate to severe, and the person is unwilling to wait for CBT to work.

The patient has significant comorbidities, including severe depression, especially if they interfere with CBT.

The patient requests medication treatment.

There is significant functional impairment in occupational and social spheres.

The patient refuses or does not respond to CBT.

- The patient is not able or willing to make arrangements to attend CBT or do the required homework.

- *Antidepressants are the first choice of pharmacological treatment, especially the SSRIs* (paroxetine, fluoxetine, fluvoxamine, citalopram, and sertraline). (Note that sertraline is not currently in the Kaiser formulary.) They may also be helpful with concurrent depression. Of the TCAs, imipramine has shown efficacy, though its side effects are less well tolerated. Other TCAs are clomipramine and amitriptyline.

- Both SSRIs and TCAs should be initiated at very *low doses* and increased *slowly*. This is because panic patients are very vigilant about any symptoms, especially those that remind them of their anxiety symptoms, such as jitteriness or rapid heart beat.

- When the patient does not respond, another medication can be tried, e.g., another SSRI or other augmenting medications.

- If possible, benzodiazepines should be avoided. If needed, the time period should be as short as possible. *Avoid prescribing them on a prn basis, if at all possible.*

- For treatment refractory cases, consider combined treatments.

- Consideration must be given to racial/cultural differences in response to medications, e.g., being mindful of historical considerations when medicating African Americans, and taking care not to overmedicate members of Asian populations, who are often highly sensitive to medications.

RECOMMENDATIONS for IMPLEMENTING PARITY

- Kaiser clinics must be sufficiently staffed and funded to ensure that the Clinical Practice Guideline for the Treatment of Panic Disorder in Psychiatry can be implemented. This includes drawing plans to allow for timely, panic-relevant, and informative evaluations to maximize compliance on the part of the patient. Since every facility currently offers panic/phobia groups, emphasis needs to be placed on assuring that groups meet the guideline principles. Continued staff training is essential.

- Group CBT is the treatment of choice for everyone. It has been shown to be as effective as CBT, if not more so.

- The treatment must include all components with an emphasis on the *most effective* ones: cognitive restructuring, interoceptive- and in vivo exposures.

- Research indicates that treatment length be from 10 to 15 sessions, the longer versions for patients who also have agoraphobia. (Note that group lengths currently vary from 1.5 to 3 hours, which can be taken into consideration when implementing these guidelines. Usually it is indicated to run groups weekly.) Naturally, there are patients who overcome their fears quickly and well, and may thus need to stay in the group a shorter time.

- Individual therapy should be reserved for patients whose symptomatology makes them unable to benefit from group. A few patients may at times need some individual attention in addition to the group sessions. If the facility's group time precludes the patient from participating in the group, the first option should be to refer to another nearby Kaiser facility that offers a different group day or time. (Such plans should be worked out between the facilities.)

- Patients who demand general individual psychotherapy instead of CBT *should be told that this is not a treatment for panic disorder*, and should not be offered this as such treatment.

- Patients who do not have the schedule flexibility for the CBT options offered can get treatment with medications.

- Patients with *no or mild agoraphobia* who do choose pharmacotherapy are best offered *CBT to coincide with the medication discontinuation phase*. Those with *moderate to severe agoraphobia, significant comorbidities, and/or significant functional impairment* can get both treatments concurrently, or either treatment alone, as indicated. If a patient discontinues medication, CBT could be offered to coincide with the taper. Some patients will need long-term pharmacotherapy.

- Patients should be able to repeat CBT and/or pharmacotherapy.

- Providing CBT booster sessions or an ongoing support group (which could meet biweekly or monthly) after cessation of the main treatment is desirable. This would focus on maintenance and further growth, as well as helping patients cope with new stressors that might put them at risk for relapse.

Providers need to be culturally sensitive and trained in the work with minority patients.

- High-quality training should be provided for a few therapists identified as panic disorder specialists.
- Patients may benefit from Behavioral Health Education anxiety classes, especially those unwilling to receive treatment in Psychiatry/Mental Health. However, this is *not* considered treatment for panic disorder.
- Effort should be made by Primary Care and Behavioral Medicine providers to briefly assess and educate the patient about panic disorder, including informing them about CBT, not only pharmacotherapy. Patients should not automatically be prescribed medications. A referral to Psychiatry/Mental Health should be offered, since this is where the expertise resides in treating this condition. If the patient refuses, then medications may be in order. However, as the provider continues to work with the patient, a referral to Psychiatry/Mental Health for CBT should be promoted as much as possible.

- **Group Best Practices Codes:** The authorized codes to be used, provided all treatment components are included, with *emphasis on the cognitive restructuring, interoceptive exposure and in vivo exposure* are:

AXPDOS = Anxiety, Panic Disorder withOut Agoraphobia, Short group length: 6 to 7 sessions.

AXPDOM = Anxiety, Panic Disorder withOut Agoraphobia, Medium group length: 8 to 9 sessions.

AXPDOL = Anxiety, Panic Disorder withOut Agoraphobia, Long group length: 10+ sessions, or ongoing.

AXPDAS = Anxiety, Panic Disorder with Agoraphobia, Short group length: 8 to 9 sessions.

AXPDAM = Anxiety, Panic Disorder with Agoraphobia, Medium group length: 10-11 sessions.

AXPDAL = Anxiety, Panic Disorder with Agoraphobia, Long group length: 12+ sessions, or ongoing.

(Note: These group codes are not to be used for panic patients who are mixed with patients with other diagnoses unless *all treatment components are present to a significant degree.*)

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Panic Disorder

SUMMARY CARD *for* DIAGNOSING & TREATING PANIC DISORDER *in* PSYCHIATRY*

DIAGNOSTIC CRITERIA**

PANIC ATTACK

A SUDDEN RUSH OF FEAR OR IMPENDING DOOM, *with at least 4 of the following:*

- Palpitations
- Sweating
- Trembling or shaking
- Sensations of shortness of breath
- Feeling of choking
- Chest pain or discomfort
- Nausea or dizziness
- Feeling lightheaded, faint
- Feelings of unreality
- Hot flushes or chills
- Numbness or tingling
- Fear of losing control or going crazy

Both, FOR AT LEAST 1 MONTH:

- Recurrent, "out of the blue" panic attacks, *and*
- Fear of panic symptoms or of their implications, e.g., fear of having a heart attack, going crazy, losing control, fainting.

... WITH AGORAPHOBIA

- Avoidance of situations or activities for fear of having a panic attack.

PROVIDER'S FIRST RESPONSE

- **EDUCATE** ... about the nature of the diagnosis, e.g., "Panic attacks are the body's alarm system going off at the wrong time." "Panic disorder has to do with fear of uncomfortable sensations." "People think that by avoiding situations for fear of panic, the panic will go away; instead, it creates a problem: Agoraphobia."
- **EMPATHIZE** ... and validate the patient's distress, e.g., "That does sound scary. People who haven't had a panic attack don't understand what it's like." "A lot of people worry they may sound crazy or weak, but they're not; this is a real problem, not something all in your head."
- **EXPLAIN** ... the presenting symptoms; don't say "Nothing's wrong." Instead, "Those heart symptoms are different from a heart attack; your body's just mobilizing for emergency action." "That shortness of breath is caused by exhaling a little too much carbon dioxide, which can be corrected by slowing down your breathing."

EXPOSURE INSTRUCTIONS

Encourage patients to do whatever they're afraid of and to do it repeatedly and frequently, "Feel the fear and do it anyway." E.g., "Return to the scene of the panic attack, stay till your fear subsides; prioritize avoided activities, break them into small steps, and schedule the first step; tell someone else you'll do it."

BREATHING SKILLS

Until they get specialized treatment, refer patients to Health Education classes and materials. Teach breathing skills: "Become aware of your breathing, without criticizing or trying to change it. Mentally count on each exhale, and think, 'Relax' on each exhale. Count up to 10, one number per breath, then back down to 1, repeatedly for 10 minutes."

LIFESTYLE AND SUBSTANCES

Eliminate alcohol and illicit substances. Reduce caffeine. Stop smoking. Instead, increase exercise (e.g., at least 20 minutes of brisk walking 3 times a week) and increase pleasurable activities, including time with others.

* In part adapted from the Summary Card for *Clinical Practice Guidelines for Panic and Generalized Anxiety Disorders in Adult Primary Care* (1998). J. Peters, Chair.

** Adapted with permission from: *DSM-IV*® (1994), American Psychiatric Association.

FIRST-LINE TREATMENT *for* PANIC DISORDER

Cognitive-Behavior Therapy (CBT)

For panic disorder with no or milder forms of agoraphobia, the first-line treatment is cognitive-behavior therapy (CBT) without pharmacotherapy. If these patients choose medication treatment, CBT is best added at the time of medication discontinuation. For other patients, CBT can be offered at any time.

Antidepressants are the pharmacological treatment of choice! Starting doses of antidepressants for use in panic disorder should be $\frac{1}{2}$ to $\frac{1}{4}$ that used to treat depression. Panic disorder with more severe forms of agoraphobia should receive combination CBT and antidepressants. All medications used to treat anxiety disorders, including antidepressants, should be tapered when discontinued. Taper antidepressants approximately 20%-25% per week.

PHARMACOTHERAPY *of* PANIC DISORDER: ANTIDEPRESSANTS

PHARMACOLOGICAL ACTIVITY PROFILE	CLASS	MEDICATION	STARTING DOSE	TARGET DOSE* (RANGE)	COMMENTS
Serotonin (5HT) Uptake Inhibition	SSRIs	Fluoxetine (Prozac) of elixir	5 mg q am (or 2 mg q am)	20 mg q am (10 to 60 mg q am)	May be too activating for some patients
		Fluvoxamine (Luvox)	25 mg bid	50 mg bid (25 to 100 mg bid)	
		Paroxetine (Paxil)	10 mg q am	20 mg q am (10 to 50 mg q am)	
		Citalopram (Celexa) Currently Non-formulary	10 mg q am	20 mg q am (10 to 40 mg q am)	
		Sertraline (Zoloft) Currently Non-formulary	25 mg q am	100 mg q am (50 to 200 mg q am)	
Combined 5HT and Norepinephrine Uptake Inhibition	TCAs**	Imipramine (Tofranil)	10 mg q am	150 mg q hs (50 to 300 mg q hs)	Use cautiously in geriatric patients
		Clomipramine (Anafranil)	12.5 mg q am	75 mg q d (25 to 150 mg q d)	Use cautiously in geriatric patients
	Other	Venlafaxine*** (Effexor)	25 mg bid	75 mg bid (37.5 to 150 mg bid)	Monitor blood pressure, can cause hypertension
5HT Uptake Inhibition and 5HT ₂ antagonist		Nefazodone (Serzone)	50 mg bid	150 mg bid (100 to 200 mg bid)	Inhibits metabolism of many medications. May require dose adjustment

* Target dose in the elderly is 50% of the target dose listed

** Relative extent of uptake inhibition of 5HT and Norepinephrine varies with the specific TCA

*** Effexor may be converted 1:1 to Effexor XR for once a day dosing once patient is stabilized

Note: If necessary, benzodiazepines may be used adjunctively with antidepressants at the beginning of pharmacotherapy. Do not prescribe more than 2 weeks at a time, nor for more than 4 weeks total; just allow time for the antidepressant to take effect. *Avoid, if possible, prescribing PRN.*



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